STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155792	B. WINC			05/24/	2012
NAME OF I	DROVADED OD GLIDDI IE	D		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIE	K		762 N E	DAN JONES RD		
	RYSIDE MEADOW	SLLC		AVON,	IN 46123		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This wisit was fo	andla Instantiantian of	F000	00	The creation and submission of	of	
	This visit was for the Investigation of Complaint IN00108486.		1000	0	this plan of correction does no		
					constitute an admission by this		
	Complaint IN0	0108486-Substantiated.			provider of any conclusion set forth in the statement of		
	_	eficiencies related to			deficiencies, or of any violation	n of	
		e cited at F279 and F323.			regulation.This provider	- -	
	anegation(s) are	onou at 1219 and 1323.			respectfully requests that the		
	Cumuar datas N	Acre 22, 24, 2012			2567 plan of correction be		
	Survey dates. N	May 23, 24, 2012			considered the letter of credible allegation and request a Desk		
	Facility number: 012534				Review in lieu of a Post Surve		
					review on or after 6/23/12.	,	
	Provider numbe						
	AIM Number: 2	201028420					
	Survey team:						
	Lora Brettnache	er, RN, TC					
	Christi Davidso	n, RN					
	Census bed type	2:					
	SNF: 21						
	SNF/NF: 88						
	Total: 109						
	Census by payo	or type:					
	Medicare: 21						
	Medicaid: 52						
	Other: 36						
	Total: 109						
	Sample: 4						
	These deficience	ies reflect state findings					
		nce with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155792			00					
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
		completed 6/5/12 by							

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Event ID: 8XLU11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155792	B. WIN			05/24/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YSIDE MEADOWS	LLC			OAN JONES RD IN 46123		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	PLANS A facility must us assessment to d resident's compr The facility must care plan for each measurable object a resident's mental and psycidentified in the compression of the care plan mare to be furnished resident's highest mental, and psycinequired under § that would other §483.25 but are resident's exercise.	PREHENSIVE CARE se the results of the evelop, review and revise the ehensive plan of care. develop a comprehensive the resident that includes ctives and timetables to a medical, nursing, and hosocial needs that are comprehensive assessment. set describe the services that ed to attain or maintain the practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, at to refuse treatment under					
	facility failed to comprehensive presults of assess residents reviewed in a total sample. Findings include Resident B's reconstituted on 5/19 diagnoses which	ed for care plan revision of 4. (Resident B)	F02	79	This provider uses the results the assessment to devlope, review and revise the resident's comprehensive care plan. The facility developes a comprehensive care plan for each resident that includes measureable objectives and tilt tables to meet a resident's medical, nursing and mental a psychosocial needs that are identified in the comprehensive assessment. The care plan describes the services that are be furnished to attain or maintathe resident's highest paracticable physical, mental, psychococial well-being as	me nd ve e to ain	06/23/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155792	B. WIN			05/24/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	L			DAN JONES RD	
	RYSIDE MEADOWS	SLLC			IN 46123	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE -
	congestive heart	·			required.WHAT CORRECTIVE ACTIONS WILL BE	-
	_	onary disease (COPD),			ACCOMPLISHED. Resident B	3 is
	acute renal insufficiency, vascular				no longer residing in the	
	dementia with be	ehavioral disturbances,			faclity.HOW WILL YOU	
	pacemaker, anxi	ety, depression, urinary			IDENTIFY OTHER RESIDENT	
	tract infection, h	ypoxia, and recurrent			Current residents that reside in	
	pneumonia. Res	ident B was alert with			the facility have the potential to be affected by the alleged	^U
	periods of confu	sion.			deficient practice. Care plans	
	•				have been updaed to reflect th	ie
	Resident B's current signed physician's rewrite orders dated for 5/1/2012 through 5/31/2012 indicated she had activity orders to be up with assist/walker. A				results of the fall risk	
					assessments that were	
					completed on resident's currer residing in the facility. Care pl	
					are reviewed and updated on a	
	_	imum Data Assessment			quarterly basis and with any	1
					significant change in resident	
	, , , , , , , , , , , , , , , , , , , ,	ed 2/20/12, indicated			status. Care plans and aide	
	_	red extensive assistance			assignment sheets will be upd	
	•	s physical assist for toilet			during routine care plan meeting and during the morning clinica	
		d bed mobility. She			meeting as needed to reflect the	
	_	e assistance with once			current plan of care for each	
		assist for personal			resident.WHAT MEASURES	
	hygiene, walking	g in room and the			WILL BE LPUT INTO PLACE.	
	corridor. A 2/25	/2012 MDS indicated			Resident's that are admitted to	
	Resident B did n	ot walk in or out of her			the facility will have a care plan initiated that reflects the result	
	room and require	ed extensive assistance of			the fall risk assessment. Fall r	
	two staff for toil	et use, transfers, and bed			assessments will be completed	
	mobility. A 30 c				by the MDS staff/designee to	
	1	ated she did not walk in			ensure that the results of each	
		ed extensive assistance of			assessment are reflected on the plan of care. Car elan meeting	
		mobility, transfers, and			will be held for each resident a	
	toolet use. A quarterly MDS, dated 3/17/2012, indicated she required extensive assistance of two staff for bed mobility, transfers, toilet use, and				minimum of every quarter and	
					with any significant changes w	rith
					plan of care updates being ma	de
					during these meetings. This	tho
	<u> </u>				meeting will include review of t most recent fall risk assessme	
	personal hygiene	e. She required assistance				116.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155792		(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE S COMPLI 05/24 /3	ETED	
		155792	B. WING			05/24/	2012
	PROVIDER OR SUPPLIER			762 N D	DAN JONES RD IN 46123		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	in a wheel chair. MDS, dated 5/11 not ambulate, rect two staff for transuse, and persona. Resident B's curred dated 1/3/2012, a 5/10/2012, indicated to decreased osteoporosis and fractures, weakneedications, historight to not wear diagnoses listed congestive heart. Atrial fibrillation history of cerebranxiety, and cogningury related to Approaches inclutransfers between appropriate assis walker, resident. An Interdisciplinary Resident B's fall indicated the team Resident B requirements are supposed to the supposed to th	rent care plan originally and last updated atted she was a fall risk mobility with increased risk of less, pain, incontinence, lory of her exercising her or use gait belt, related included: COPD, failure (CHF), Diabetes, and dementia, anemia, all vascular accident, anition. A goal for no falls was listed. Inded: assist with an surfaces and provide tive devices such at the up ad lib with walker. Team had met to review			The clinical team will review at falls in the morning meeting ar make changes to the care plan and aide assignment sheet at time to reflect the current statu and needs of each resident. It team will be re-educated on revising the resident's comprehensive planof care an aide assignment sheet based the results of the assessments the nursing consultant on or before 6/23/12.HOW THE CORRECTIVE ACTIONS WILL BE MONITORED. A CQI aud tool named "Assessments" will utilized by the DNS and or designee to monitor compliance. Audits will be completed week for four weeks, monthly for two months, and quarterly thereaft for at least two quaarters until compliance is achieved. Result in developement of action plans and staff re-education. COMPLIANCE DATE 6/23/12	nd n this is DT d on s by L it I be ce. ly o er	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155792	B. WING		05/24/2012
NAME OF F	PROVIDER OR SUPPLIE	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				DAN JONES RD	
COUNTR	RYSIDE MEADOWS	SLLC	AVON,	IN 46123	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ent B did not attempt to			
	1	ently. PT/OT (physical			
	therapy/occupational therapy) completed.				
	Will D/C (discontinue) personal alarm to				
	bed/chair after review of chart, staff and				
	overall status. An Interdisciplinary Progress Note dated 5/11/2012-10:30 A.M. indicated the				
	Interdisciplinary Team had reviewed a fall which occurred on 5/10/2012 at 6:25 P.M.				
	This note indicated the Certified Nursing				
	,) was preparing to assist			
		ed. Resident B was sitting			
		ir near the bed. Resident			
		self toward the bed and			
		Resident B hit her head			
		ling on the left side of her			
		B was assessed, steri-strips			
		led, and her family and			
		Immediate interventions			
		e included an orthopedic			
	•	wedge cushion in the			
	wheel chair.				
	A nurgela mate	loted 5/11/12 1:00 A M			
		lated 5/11/12-1:09 A.M., ent B returned to the			
	1 *	ng discharged from the			
	_	ations were noted to			
		ys in a V shape. Stitches			
		d at hospital. A bruise to			
		outer arm and right knee,			
		ere noted. Resident B had			
	a cast on her left	arm and bilateral splints			

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	OF CORRECTION OF CORRECTION 155792	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 05/24 /	ETED		
	PROVIDER OR SUPPLIER RYSIDE MEADOWS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE		
	in place. Resident B complained of pain and a PRN (as needed) pain medicine was given. A nurse's note, dated 5/11/2012 - 10:00 A.M., indicated Resident B's laceration to forehead measured approximately 4.1 cm (centimeters) by 7.2 cm with 16 sutures noted. Resident B rated her pain 4/10. A nurse's note, dated 5/11/2012-12:00 P.M., indicated Resident B complained of pain to her left wrist and right shoulder. Resident B rated her pain a 7 on a 1-10 scale. She was given pain medicine. A care plan, dated 5/10/2012, indicated Resident B sustained a left wrist fracture from this fall. During an interview on 5/24/2012 at 10:15 A.M., the Assistant Director of Nursing (ADON) indicated CNA (Certified Nursing Assistant) #10 was in the room alone with Resident B. She had taken her to the toilet by herself, took out her dentures, put on her pajamas, transferred her back to the wheelchair alone, pushed her over by the bed then went back to the bathroom. She did not see Resident B fall but heard her fall and the nurse outside of the room heard the fall at the same time and came in to assist with Resident B. The ADON explained this is why the fall report indicated it was an unwitnessed fall. At this time the ADON was interviewed about the last several MDSs, which indicated Resident						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE (COMPL	
1111212111	or conditions	155792		LDING		05/24/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				OAN JONES RD		
COUNTR	RYSIDE MEADOWS	SLLC			IN 46123		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ssistance of two staff for		TAG	Dia lettike 1		DATE
	*	g, and bed mobility, and					
		olan that currently					
		ald be up with a walker					
	ad lib and did no	_					
		the need for two staff for					
		leting, and transfers,					
		n wheelchair, or to be in					
	_	to staff while in the wheel					
		N was unable to provide					
		*					
an explanation as to why the care plan had not been updated to reflect the current							
	assessed needs of the resident.						
	assessed fields 0	i the resident.					
	During an interv	iew on 5/24/12 at 11:20					
	_	Sanager indicated the					
	i -	Nursing Assistants) were					
		ts with information on the					
	"	f residents. They					
		the care plan but were					
	_	ily meetings and the 24					
		s. She indicated the					
		ave the forms and					
	l *	t B had been discharged					
		o provide documentation					
	of her assignmen	-					
	During an interv	iew on 5/24/2012 at					
	12:10 P.M., the A	Administrator indicated					
	the facility did no	ot have any additional					
	I -	ch indicated Resident B's					
	care plan had bee	en revised to reflect her					
	•	d interventions to prevent					
	falls.	-					
	l .						ıİ

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		ATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 05/24	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123						
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT	BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CCTION ULD BE PROPRIATE	(X5) COMPLETION DATE			
		TIFYING INFORMATION)		CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		155792	A. BUII B. WIN			05/24/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP CODE		
COLINITE	WOIDE MEADOWO				DAN JONES RD		
COUNTR	RYSIDE MEADOWS	LLC		AVON,	IN 46123		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0323	483.25(h)					•	
SS=D	FREE OF ACCID	DENT					
	HAZARDS/SUP	ERVISION/DEVICES					
	The facility must ensure that the resident						
		nains as free of accident					
	hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.						
		•	F03	23	It is the practice of this provide	or	06/23/2012
		review and interview, the	1.03	43	It is the practice of this provide to ensure that the resident	CI CI	00/23/2012
	_	ensure each resident			environment remains free of		
	•	e supervision and			accident hazards as is possibl	e:	
	assistance to prev	vent accidents for 1 of 3			and each residnet receives		
	residents reviewed for the prevention of accidents (Resident B).				adequate supervision and assistance devices to prevent		
	`	,			accidents.WHAT CORRECTIV		
	Findings include				ACTION. Resident B is no lor	-	
	Tillulings illerude	•			residing inthe facility.HOW WII YOU IDENTIFY OTHER	LL	
					RESIDENTS Current resident	e	
		ord was reviewed on			residing in the facility have the	J	
	5/23/2012 at 12:3	30 P.M. Resident B was			potential to be affected by the		
	admitted on 5/19	/2011 and had current			alleged deficient practice. Fall		
	diagnoses which	included, but were not			risk assessments for current		
	_	tension, diabetes type II,			resident's residing in the facilit	y	
	congestive heart				have been updated to reflect		
	•	·			current and accurate resident		
	•	onary disease (COPD),			information. Current resident's		
		ficiency, vascular			identified as being at risk for fa		
	dementia with be	ehavioral disturbances,			have had their comprehensive are plans and aide assignmen		
	pacemaker, anxie	ety, depression, urinary			sheets reviewed to ensure tha		
	tract infection, h	ypoxia, and recurrent			they reflect the current resider		
		ident B was alert with			needs and accurate and	-	
	periods of confus				implemented interventions and	t	
	portous of confus				risk factors.WHAT MEASURE	S	
	D				WILL BE PUT IN PLACE.		
		rent signed physician's			Resident's admitted to the faci	•	
		ated for 5/1/2012 through			who are at risk for falls will have		
	5/31/2012, indica	ated she had activity			fall risk assessment completed		
	order's to be up v	with assist/walker.			and a care plan initiated to refl	ect	
					current resident needs and		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155792	B. WIN	IG		05/24/20	112
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
COLINTE	RYSIDE MEADOWS	211.0			DAN JONES RD IN 46123		
					111 40123	ı	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION DATE
TAG		dmission Minimum Data	+	IAG	accurate information. Fall risk		DATE
					assessments will continue to b		
		l (MDS), dated 2/20/12,			updated quarterly and as need	ded	
		nt B required extensive			with results of the assessmen	s	
		wo person physical assist			updated on the plan of care. CNA assignments sheets and		
		nsfers, and bed mobility.			care plans will be updated and	1	
		ensive assistance with			revised in the morning clinical		
		sical assist for personal			meeting and available to all st		
	''	g in her room and the			caring for the resident's. Nurs		
		5/2012 MDS indicated			managers or chare nurses will conduct rounds on each shift		
	Resident B did not walk in or out of her room and required extensive assistance of two staff for toilet use, transfers, and bed				ensure aide assignment sheet		
					are being followed. Nursing s		
					will be re-educated by the		
	mobility. A 30 c				SDC/designee on ensuring resident's receive adequate		
	-	ated she did not walk in			suerpvision and assistance to		
		ed extensive assistance of			prevent accidents on or before	,	
		mobility, transfers, and			6/23/12HOW THE CORRECT		
	_	arterly MDS, dated			ACTION WILL BE MONITORI	ED.	
		ated she required			A CQI audti tool named "Fall Management" will be utilized t	nv	
		nce of two staff for bed			the DNS and /or designee to	,	
	<u>-</u>	rs, toilet use, and			monitor for compliance wth fal	l	
		e. She required assistance			interventions. Audits will be		
		nobility off unit once in a			completed weekly for four wee monthly for two months, and	eks,	
		ignificant change MDS,			quaarterly thereafter for at lea	st	
		, indicated she did not			two quaters until compliance is		
	, A	ed extensive assist of two			achieved. Results of the		
		s, bed mobility, toilet use,			evaluations/processes will be presented to the CQI committee		
	and personal hyg	giene.			montly to review for compliance		
					and follow up. Identified	-	
	Review of Resid	ent B's current care plan,			non-compliance may result in		
	originally dated	1/3/2012, and last			development of action plans a		
	updated 5/10/20	12, indicated she was a			staff re-education.COMPLIAN DATE 6/23/12		
	fall risk due to d	ecreased mobility with			2.112 0.20/12		
	osteoporosis and	increased risk of					
	fractures, weakn	ess, pain, incontinence,					

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Event ID: 8XLU11

Facility ID: 012534

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PRINTED: 07/06/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE (COMPL	
		155792		LDING		05/24/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OAN JONES RD		
COUNTR	RYSIDE MEADOWS	SLLC			IN 46123		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		cory of her exercising her		TAG	,		DATE
	· ·	or use a gait belt, related					
	_	included: COPD,					
	•	failure (CHF), diabetes,					
	_	, dementia, anemia,					
	· ·	al vascular accident,					
	1 -	nition. A goal for no					
	injury related to	•					
	Approaches inclu						
	* *	n surfaces and provide					
appropriate assistive devices such as							
walker, resident up ad lib with a walker.							
	,						
	An Interdisciplin	ary Progress Note, dated					
	4/16/2012-9:30 I	P.M., indicated the					
		Team had met to review					
		risks. Resident B					
	required total ass	<u> </u>					
	1 -	ooming and two person					
		nobility, and transfers.					
		ot attempt to get up					
	independently. I	~ J					
		onal therapy) completed.					
	`	ntinue) personal alarm to					
		eview of chart, staff and					
	overall status.						
	An Interdisciplin	ary Progress Note, dated					
	_	A.M., indicated the					
		Team reviewed a fall					
		on 5/10/2012 at 6:25 P.M.					
		ed the Certified Nursing					
		was preparing to assist					
		d. The resident was					

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/24/2012			
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Resident B proper bed and fell to the her head on the fixed of her arm. Steri-strips applied and doctor notificated resident follow-up and a wheel chair. A nurse's note, doindicated Resident forehead sideway were applied at the right upper of right eye were not cast on her left at place. Resident PRN (as needed) given. A nurse's 10:00 A.M., indicated laceration to her approximately 4. 7.2 cm with 16 strated her pain a 2 nurse's note, date indicated Resident B rated scale. She was generally approximated and the stated scale she was generally approximated and the stated scale. She was generally approximated and the stated scale she was generally approximately approximately 4.	cell chair near the bed. celled herself toward the e floor. Resident B hit floor landing on the left Resident B was assessed, ed, 911 called, and family ed. Interventions to be aded an orthopedic wedge cushion in the atted 5/11/12-1:09 A.M., int B had returned to the ing discharged from the ration was noted to her ivs in a V shape. Stitches the hospital. A bruise to inter arm, right knee, and oted. Resident B had a rm and bilateral splints in B complained of pain and pain medicine was note, dated 5/11/2012 - ceated Resident B's forehead measured 1 cm (centimeters) by intures noted. Resident B is on a 1/10 scale. A interventions to be and the following the following the following the following the interventions to be and the following the following the following the interventions to be and 5/11/2012 - to cated Resident B's forehead measured 1 cm (centimeters) by intures noted. Resident B is on a 1/10 scale. A interventions to be and the following the following the following the following the interventions to be and the following the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the following the interventions to be and the following the interventions the following the interventions						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
	155792		B. WING			05/24/2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
			762 N DAN JONES RD AVON, IN 46123				
COUNTRYSIDE MEADOWS LLC					IIN 40 123		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) Resident B sustained a left wrist fracture			TAG		DATE	
		med a left wrist fracture					
	mom uns ian.	from this fall.					
	During an intervi	iew on 5/24/2012 at					
	During an interview on 5/24/2012 at						
	10:15 A.M., the Assistant Director of Nursing (ADON) indicated on 5/10/2012,						
	_ · ·	Nursing Assistant) #10					
	,	alone with Resident B.					
		er to the toilet by herself,					
		-					
	took out her dentures, put on her pajamas, transferred her back to the wheelchair						
	alone, pushed her over by the bed then						
	went back to the bathroom. She did not						
		all but heard her fall and					
		of the room heard the					
		ime and came in to assist					
		The ADON explained					
		all report indicated it was					
		fall. At this time the					
		tioned about the last					
		n Data Assessments					
	(MDS) which indicated Resident B						
	required the assistance of two staff for						
		g, and bed mobility, and					
		plan that still indicated					
		with a walker ad lib and					
	_	interventions of the need					
		bed mobility, toileting,					
		l chair wedge cushion, or					
		close proximity to staff					
		heel chair. The ADON					
	-	ovide an explanation as					
	_	plan had not been updated					
		rent assessed needs of the					

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		IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
THIE TEAT	155792			LDING		05/24/		
		.00.02	B. WIN		DDDECC CITY CTATE 7ID CODE	33.2		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD					
COUNTRYSIDE MEADOWS LLC			AVON, IN 46123					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
IAG		nation which indicated		TAG	DEFICIENCT)		DATE	
		ated or implemented						
	interventions, inc							
		spervision consistent with essed needs during						
		•						
		eting prior to or after her						
	1an on 3/10/2012	2 which resulted in injury.						
	During an interv	iew on 5/24/12 at 11:20						
	A.M., the Unit M	Ianager indicated the						
	CNAs (Certified	Nursing Assistants) were						
	given daily sheet	ts with information on the						
	assessed needs o	f residents. They						
	originated from the care plan but were							
	updated from dai	ily meetings and the 24						
	hour report sheet	s. She indicated the						
	facility did not sa	ave the forms. Because						
	Resident B had b	been discharged, she was						
	unable to provide	e documentation of her						
	assignment sheet	ts which indicated CNA						
	#10 was aware o	f Resident B's fall risk or						
	the need for two	staff to assist with						
	transfers and toil	eting.						
	This federal tag i	is related to Complaint						
	IN00108486.							
	3.1-45(a)(2)							

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